CONSENT FOR MEDICAL TREATMENT

To the Patient: You have the right to be informed about your condition and the recommended examination, surgical, medical, or diagnostic procedure to be used, so that you may make the decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is simply an effort to make you better informed so that you may give or withhold your consent.

1. I, ____ hereby voluntary consent to treatment at Genesis Vascular of Salt Lake, LLC and authorize examinations, diagnostic procedures and treatments including but not limited to the use of x-rays, lab specimens, medications, anesthesia of surgical procedures as by my be ordered by the provider on duty.
2. The nature, purpose and goals of the proposed examination, procedure(s), risks, benefits, possible discomforts and recuperations involved, any reasonable alternatives, and the possibility of complications have been explained to my satisfaction.
3. The relevant risks, benefits, and side effects related to alternatives, including the possible results or not receiving care, treatment and services have been discussed with me.
4. I consent to the photographing or closed circuit televising of the operation(s) or procedure(s) to be performed including appropriate portions of the body, for medical, scientific, or educational purposes proved that the identity is not revealed by the pictures or by the descriptive texts accompanying them.
5. For the purposes of advancing medical education, I consent to the admittance of observers to the operating and/or procedure room, including but not limited to, medical students, nursing students, and representatives of manufacturers of medical equipment.
6. I understand that my physician may have a financial interest in the facility that I am having my procedure done.

If any of the first six items are stricken or altered, this informed consent form may not be effective the physician must concur before proceeding further.
I have been given the opportunity to ask questions about my condition, alternative forms of treatment and anesthesia, risks of non-treatment, the procedures to be used, and the risks and hazards involved. I believe that I have sufficient information to give this informed consent. I certify that I have read and fully understand this consent form, that the explanations referred to were made, that I have no further questions about the treatment to be given, and that all blanks or statements requiring insertion or completion were filled in or stricken before I signed.

Date:______/_______/_______ Time:______________
Signature of Patient or Family Member:____
Signature of Witness:____
Provider Signature:____

We, at Genesis Vascular of Salt Lake, LLC, are committed to safeguarding the privacy and confidentially of your medical records including the personal information that you with us. We comply with the Health Insurance Portability and accountability Act of 1996 (HIPAA). From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible. To assist us in protecting your privacy, please complete the following:

Patient Name: ____
I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CIRCLE ALL THAT APPLY)

HOME PHONE: ____
LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO
LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

WORK PHONE: ____
MAY WE CALL YOU AT WORK? YES NO
LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO
LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

CELLPHONE: ____
LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO
LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

May we speak to someone else regarding your medical care? YES NO

Name of Person:____

Relationship: ____

Signature: ____ Date: ___________________

PATIENT HISTORY FORM

Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____
Last First M. I.

Age:___________ Sex: ❑ F ❑ M

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Please name the referring clinic or practitioner: ____

CURRENT MEDICATIONS		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

DRUG ALLERGIES
Do you have any drug allergies? ❑ Yes ❑ No If **yes** please list them below.
1.
2.
3.
4.
5.
6.

PREFERRED PHARMACY
Name of Pharmacy:
Address: Phone Number:

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ___________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

____

____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

____

GENESIS VASCULAR

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

❑Smoking How many_____pks/day

Type: ___________ _____times/day

❑Alcohol ______drinks/wk

❑Illegal Drugs ______times/day

Have you quit in the last 3 years? _____

AUTHORIZATION TO RELEASE HEALTHCARE RECORDS/INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ All records

☐ Laboratory/Pathology records

☐ X-ray/Radiology records

☐ Billing records

☐ Pharmacy/Prescription records

☐ Other: ____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

☐ Yes ☐ No I authorize the release of my medical records regarding all treatments, procedures and/or visits to the person(s) listed above.

Patient Signature: ______________________________ Date Signed: ______________________

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PATIENT INFORMATION					
Patient Last Name:		First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ☐ Yes ☐No	If not, what is your legal name?	(Former Name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Email address:____ Alternative Email (if any):__________________________________

Street address:		Social Security No:	Phone Number: ( )
P.O. box:	City:	State:	ZIP code:
Are you currently employed? ☐ Yes ☐ No	Employer:		Employer Phone No: ( )

Do you currently reside in a Nursing Home or Rehab Facility? ☐ Yes ☐ No

Referred to center by:

INSURANCE INFORMATION				
PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST				
Person responsible for bill:	Birth date: (if different) / /	Address (if different):		Phone Number: ( )
Is this patient covered by insurance? ☐ Yes ☐ No				
Please indicate **PRIMARY** insurance	☐ MEDICARE	☐ MEDICAID	☐ Other:________________________________	
Subscriber name:	Subscriber's SSN	Birth date: / /	Group No:	Policy No:
Patient relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other:
Name of **SECONDARY** insurance	Subscriber's name:		Group No:	Policy No:
Patient relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other:
Name of **TERTIARY** insurance	Subscriber's name:		Group No:	Policy No:
Patient relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other:

IN CASE OF EMERGENCY			
Name contact:	Relationship to patient:	Home Phone Number: ( )	Cell Phone Number: ( )

PATIENT CONSENT

Please Initial

__________ The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Genesis Vascular of Salt Lake, LLC (GVSL) or the insurance company to release any information required to process my claims.

__________ I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, healthcare providers, and insurance case managers, for the purposes of processing my claims.

__________ I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. I authorize direct payment of medical benefits to GVSL for services billed.

_________ I hereby give my consent for GVSL to use & disclose my protected health information (PHI) about me to carry out treatment, payment & health care operations. (The GVSL Notice of Privacy Practices describes information used.)

_________ I have the right to review the Notice of Privacy Practices prior to sign this consent. GVSL reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices prior to signing this consent. GVSL reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by written request to the Facility Manager.

_________ With this consent, GVSL may call my home or other alternative locations and leave a message on a voice mail or with a person of reference to any items that assist the practice such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, and other medical information.

_________ With this consent, GVSL may mail to my home or other alternative location any item that assists the practice in carrying out healthcare operations, such as appointment reminder cards and patient statements.

________ With this consent, GVSL may email the address provided with any item that assists the practice in carrying out healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that GVSL restrict how it used or discloses PHI. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow GVSL to use & disclose my PHI to carry out healthcare operations.
I may revoke my consent in writing except to extent that the practice has already make disclosure in reliance upon my prior consent. If I do not sign this consent or later revoke it, GVSL may decline to provide me treatment.

______________________________	______________________________	______________
Patient/Guardian Signature	*Print Name*	*Date*

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